Garden City Hospital

Center for Sleep Disorders
Specialty Centers of Westland
35600 Central City Parkway, Suite 103
Westland, MI 48185
Phone: 734-458-3330 Fax: 734-458-3331

Screening Questionnaire

Please complete and return to your physician

Name: _____ Date: _____

How likely are you to doze off or fall asleep in the following situations?

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Circle the appropriate number

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g., a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch, without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total from above: _____(> I 0?)

Do you often feel sleepy during the daytime?	☐ Yes	☐ No
Do you snore, or has anyone ever told you that you snore?	☐ Yes	☐ No
Has anyone ever told you that you stop breathing during sleep?	☐ Yes	☐ No
Do you ever have a choking or gasping sensation during sleep?	☐ Yes	☐ No
Do your legs "kick" during sleep?	☐ Yes	☐ No

Return form to your physician